RY2014
EOHHS Technical Specifications Manual for
MassHealth Acute Hospital Quality Measures (Version 7.0)

Appendix A-8:
Consolidated Data Dictionary for MassHealth Specific Measures

Enhancements to Consolidated Data Dictionary (v 7.0)

The Appendix A-8 contains the full set of clinical and administrative data element definitions that apply to all MassHealth Specific Measures reporting requirements listed in Section 2 Table 2.1 of this EOHHS Manual.

This data dictionary should be used in conjunction with Section 3 measure descriptions along with Section 6 (Table 6.1) list of data elements that are subject to validation scoring. It also includes definitions for the administrative data elements (MassHealth patient identifiers, payer source, race/ethnicity, etc.) required to prepare all MassHealth Payer Files and MassHealth Crosswalk Files data files.

This version of the dictionary contains changes to data elements effective with Q3-2013 as summarized below.

Summary of Data Dictionary Updates (v 7.0)

Change to Dictionary	Maternity Measures (MAT-1, 2a, 2b, 3)	Care Coordination Measures (CCM-1, 2, 3)	All MassHealth Records
Existing Data Element	• *Gestational Age* • *Labor* • *Prior Uterine Surgery*	• *Advance Care Plan* • *Contact Information 24h/7d* • *Contact Information for Studies Pending* • *Current Medication List* • *Discharge Diagnosis* • *Medical Procedures and Tests & Summary of Results* • *Patient Instructions* • *Plan for Follow Up Care* • *Primary Physician/ HCP for Follow Up Care* • *Transition Record* • *Transmission Date*	• *Admission Date* • *Discharge Disposition* • *Ethnicity* • *Hispanic Indicator* • *Hospital Bill Number* • *Payer Source* • *Provider ID* • *Race*
Add New Data Element	• N/A	• N/A	• N/A

All updates to data elements are shown in *underlined italic font* throughout this data dictionary. The table of contents lists each data element alphabetically, the measure it is being collected for, and page number locator.

Data Dictionary Format and Terms

This data dictionary contains detailed *information and instruction for abstracting and formatting the collection of all measure data elements using the following format:*

- *Data Element Name*: A short phrase identifying the data element.
- *Collected For*: Identifies the measure(s) requiring that data element to be collected.
- *Definition*: A detailed explanation of the data element.
- *Suggested Data Collection Question*: The wording for a data element question in a data abstraction tool.
- *Format: Length*: The number of characters or digits allowed for the data element.
- *Type*: The type of information the data element contains (e.g., numeric, alphanumeric, date, character, or time).
- *Occurs*: The number of times the data element occurs in a single episode of care record.
- *Allowable Values*: A list of acceptable responses for this data element.
- *Notes for Abstraction*: Notes to assist abstractor in the selection of appropriate value for a data element.
- *Suggested Data Sources*: Source document from which data may be identified such as administrative or medical record. Please note the data sources listed are not intended to reflect a comprehensive list.
- *Guidelines for Abstraction*: Notes to assist abstractors in determining how data element inclusions/exclusions should be answered.

Adherence to data dictionary definitions *and instructions* provided in this EOHHS manual are *required* to ensure that data element abstraction is accurate and reliable.

Contact the MassQEX Help Desk: at (781) 419-2818 or massqexhelp@masspro.org if you have questions about information contained in this dictionary.

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Data Element Name: Admission Date

Collected For: All MassHealth Records

Definition: The month, day, and year of admission to acute inpatient care.

Suggested Data
Collection Question: What is the date the patient was admitted to acute inpatient care?

Format:

Length:	10 – MM-DD-YYYY (includes dashes)	
Type:	Date	
Occurs:	1	

Allowable Values:

MM	=	Month (01-12)
DD	=	Day (01-31)
YYYY	=	Year (2000 – 9999)

Notes for Abstraction: The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.

For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.
Example:
Preoperative orders dated 4-6-20xx with an order to admit Inpatient. Postoperative orders, dated 5-1-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 5-1-20xx. The admission date would be abstracted as 5-1-20xx.

Suggested Data Sources: ***PRIORITY ORDER FOR THESE SOURCES***
Physician orders
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	Admit to observation Arrival date

Data Element Name: Admission Time

Collected For: MAT-1

Definition: The time (military time) of admission to the Labor and Delivery unit.

Suggested Data Collection Question: At what time was the mother admitted to the Labor and Delivery unit?

Format:

Length:	5 – HH:MM (with or without colon) *or UTD*
Type:	Time
Occurs:	1

Allowable Values:

HH	=	Hour (00-23)
MM	=	Minutes (00-59)
UTD	=	Unable to Determine

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Correct Entry			*Correct Entry*
Midnight = 00:00		Noon =	12:00
5:31 am = 05:31		5:31 pm =	17:31
11:59 am = 11:59		11:59 pm =	23:59

Notes for Abstraction: Time must be abstracted in military time format.

For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the time that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the time that the patient was admitted to Observation.

00:00 = midnight.

If the time of admission is unable to be determined from medical record documentation, enter "UTD".

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Advance Care Plan

Collected For: CCM-2

Definition: An Advance Care Plan refers to a written statement of patient instructions or wishes regarding future use of life sustaining medical treatment. This data element may also be called advance directive, living will, healthcare proxy, DNR, power of attorney.

A transition record that included documentation of an Advance Care Plan or a documented reason for not providing an advance care plan.

Suggested Data Collection Question: Does the Transition Record include documentation of an Advance Care Plan?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes)   The transition record includes documentation of an Advance Care Plan or a documented reason for not providing an advance care plan.

N (No)   The transition record does not include documentation of an Advance Care Plan or a documented reason for not providing an advance care plan.

Notes for Abstraction: The presence of an advance care plan must be documented on the transition record for all patients 18 years and over.

A checkbox or documentation of the presence of an advance directive, health care proxy, power of attorney, etc must be documented.

If there is no advance care plan, a reason must be documented.

A documented reason for not providing an advance care plan includes:
- The care plan was discussed but the patient did not wish or was not able to name a health care proxy
- The patient was not able to provide an advance care plan
- Documentation as appropriate that the patient's cultural and/ or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician patient relationship
- The patient was < 18 years of age (calculated from Date of Birth and Admission Date)
- Patient refusal of advance care plan information or decision for an advance care plan, select Y(Yes)

Documentation in the medical record that there is no advance care plan without a reason does not meet the requirement.

A copy of the Advance Directive is not required to be attached to the transition record.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
Advance Care Directives Power of Attorney	Patients < 18 years of age

Health care proxy Do Not Resuscitate – DNR etc Living Will Documentation of code status: Full Code	

Data Element Name: Amniotic Membrane Rupture 18 or More Hours

Collected For: MAT-1

Definition: Documentation of amniotic membrane rupture for 18 or more hours.

**Suggested Data
Collection Question:** Is there documentation that the amniotic membranes were ruptured
for 18 or more hours?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) There is documentation that the amniotic membranes
were ruptured for 18 hours or longer.

N (No) There is no documentation that the amniotic membranes were
ruptured for 18 hours or longer or duration of amniotic
membrane rupture cannot be determined from medical record
documentation.

Notes for Abstraction: None

Suggested Data Sources: History and physical
Nursing notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Antibiotic Administration Date

Collected For: MAT-1, MAT-2a

Definition: The date (month, date, and year) for which an antibiotic dose was administered.

**Suggested Data
Collection Question:** What was the date of administration for the antibiotic dose?

Format:

Length:		10 – MM-DD-YYYY (includes dashes) *or UTD*
Type:		Date
Occurs:		1

Allowable Values:

MM	=	Month (0-12)
DD	=	Day (01-31)
YYYY	=	Year (2000 – 9999)
UTD	=	*Unable to Determine*

Notes for Abstraction: Only one administration of an antibiotic is abstracted.

For MAT-1, if the antibiotic was administered on multiple occasions, abstract the date of the last dose administered before birth.

For MAT-2a, abstract the administration date that falls within, or closest, to the targeted time frame (one hour prior to Cesarean Section incision time).

If the date an antibiotic was administered is unable to be determined from medical record documentation, enter "UTD".

When converting midnight or 24:00 to 00:00, do not forget to change the Antibiotic Administration Date. Example: midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

Suggested Data Sources: IV flowsheets
Medication administration record (MAR)
Nursing notes
Perfusion record

For MAT-2a, these additional sources may also be utilized
Anesthesia record
Delivery note
Operating room record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Antibiotic Administration Time
Collected For:	MAT-1, MAT-2a
Definition:	The time (military time) for which an antibiotic dose was administered.
Suggested Data Collection Question:	What was the time of administration for the antibiotic dose?

Format:

Length:		5 – HH:MM (with or without colon) or UTD
Type:		Time
Occurs:		1

Allowable Values:

HH	=	Hour (00-23)
MM	=	Minutes (00-59)
UTD	=	Unable to Determine

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

	Correct Entry			Correct Entry
Midnight =	00:00	Noon	=	12:00
5:31 am =	05:31	5:31 pm =		17:31
11:59 am =	11:59	11:59 pm =		23:59

Notes for Abstraction:

00:00 = midnight

When converting midnight or 24:00 to 00:00, do not forget to change the Antibiotic Administration Date. Example: midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

When collecting the time of administration of an antibiotic administered via infusion (IV), Antibiotic Administration Time refers to the time the antibiotic infusion was started.

For MAT-1, if the antibiotic was administered on multiple occasions, abstract the time of the last dose administered before birth.

For MAT-2a, abstract the administration time that falls within, or closest, to the targeted time frame (one hour prior to Cesarean Section incision time).

If multiple administration times are documented for an antibiotic dose, abstract the time recorded by the clinician administering the drug. If more than one time is documented by the same clinician for the same medication dose, abstract the earliest time documented by that clinician. If it is unclear who administered the drug, abstract the earliest time documented for that dose.

If the time an antibiotic was administered is unable to be determined from medical record documentation, enter "UTD".

If the antibiotic time is documented in a grid, measure from the midpoint of the symbol, arrow, number or letter. If the value falls between two lines on the grid, abstract the earliest value.

Suggested Data Sources: IV flowsheets
Medication administration record (MAR)
Nursing notes
Perfusion record

For MAT-2a, these additional sources may also be utilized
Anesthesia record
Delivery note
Operating room record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Antibiotic Name for Cesarean Section Prophylaxis

Collected For: MAT-2b

Definition: A code indicating the name of the IV antibiotic administered for Cesarean section surgical prophylaxis.

Suggested Data Collection Question: What is the antibiotic name of the IV antibiotic administered for Cesarean section surgical prophylaxis?

Format:

Length:	2	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values:

1 = Ampicillin
2 = Cefazolin
3 = Gentamycin
4 = Other

Notes for Abstraction: Data is collected on one *intravenous* antibiotic administered within the targeted time frame, i.e., within one (1) hour prior to surgical incision.

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Only the allowable values should be abstracted. For a crosswalk of Trade and Generic Names, consult Table 2.1 of Appendix C in the appropriate version of the NHIQM Specifications Manual. If the medical record contains two antibiotic names within the appropriate timeframe, abstract the antibiotic name that matches one of the names on the list of allowable values first before choosing an "Other" antibiotic.

A physician order is not sufficient to abstract this data, there must be documentation that the medication was administered.

Suggested Data Sources: Anesthesia record
IV flowsheet
Labor and delivery flow sheet
Labor and delivery summary
Medication administration record (MAR)
Nursing notes
Operative report
Operating room record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Antibiotic Name for GBS Prophylaxis

Collected For:	MAT-1

Definition:	A code indicating the name of the IV antibiotic administered for GBS prophylaxis.

Suggested Data Collection Question:	What is the name of the IV antibiotic administered for GBS prophylaxis?

Format:	**Length:**	2
	Type:	Alphanumeric
	Occurs:	1

Allowable Values:	1 = Ampicillin
	2 = Cefazolin
	3 = Clindamycin
	5 = Penicillin
	6 = Vancomycin
	7 = Other

Note: (4= Erythromycin has been removed as a recommended choice for prophylaxis)

Notes for Abstraction:	Data is collected on the last administration of the intrapartum intravenous antibiotic for GBS prophylaxis.
	Only the allowable values should be abstracted. For a crosswalk of Trade and Generic Names, consult Table 2.1 of Appendix C in the appropriate version of the NHIQM Specifications Manual. If the medical record contains two antibiotic names within the appropriate timeframe, abstract the antibiotic name that matches one of the names on the list of allowable values first before choosing an "Other" antibiotic.
	A physician order is not sufficient to abstract this data; there must be documentation that the medication was administered.

Suggested Data Sources:	Delivery room record
	IV flowsheet
	Labor and delivery flow sheet
	Labor and delivery summary
	Medication administration record (MAR)
	Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Birthdate

Collected For: All MassHealth Records

Definition: The month, day, and year the patient was born.

NOTE: Patient's age (in years) is calculated by *Admission Date* minus *Birthdate.* The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age**.**

**Suggested Data
Collection Question:** What is the patient's date of birth?

Format:

Length:		10 – MM-DD-YYYY (includes dashes)
Type:		Date
Occurs:		1

Allowable Values:

MM	=	Month (01-12)
DD	=	Day (01-31)
YYYY	=	Year (1880 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources: Emergency department record
Face sheet
Registration form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Cesarean Delivery

Collected For: MAT-1

Definition: Documentation that a Cesarean delivery prior to Onset of Labor with Intact Membranes was performed.

Suggested Data Collection Question: Is there documentation that a Cesarean delivery was performed prior to the onset of labor with intact membranes?

Format:
Length:	1	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values:

Y (Yes)   There is documentation that a Cesarean delivery prior to the onset of labor with intact membranes was performed.

N (No)   There is no documentation that a Cesarean delivery prior to the onset of labor with intact membranes was performed.

Notes for Abstraction: Both conditions must be met (prior to onset of labor with intact membranes) in order to select Y (Yes).

If there is documentation of "labor" by the physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant, or registered nurse, select N (No).

If it is unclear if membranes have ruptured (ie question of leak) or no clear documentation of ruptured membranes AND prior to onset of labor, select Y (Yes).

Suggested Data Sources: Delivery note
Discharge summary
History and physical
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Cesarean Section Incision Time
Collected For:	MAT-2a
Definition:	The time (military time) the initial incision was made for the Cesarean section procedure.
Suggested Data Collection Question:	At what time was the initial incision made for the Cesarean section procedure?

Format:

Length:		5 – HH:MM (with or without colon) *or UTD*
Type:		Time
Occurs:		1

Allowable Values:

HH	=	Hour (00-23)
MM	=	Minutes (00-59)
UTD	=	*Unable to Determine*

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Correct Entry			Correct Entry		
Midnight =	00:00		Noon	=	12:00
5:31 am =	05:31		5:31 pm	=	17:31
11:59 am =	11:59		11:59 pm	=	23:59

Notes for Abstraction: Follow the priority order below. If multiple times are found, abstract the earliest time found within the highest priority grouping.

First Priority: Incision Time = Cut time

Second Priority:
- Begin time
- Operation start time
- Procedure start time
- Start of surgery (SOS)
- Surgery start time
- Symbol used on grid and indicated in legend to be incision time

Third Priority:
- Skin time

Fourth priority:
- Anesthesia begin time
- Anesthesia start time
- Operating room start time

Example #1: If surgery start time is documented at 10:10 and skin time is documented at 10:05, abstract 10:10 for the data element Cesarean Section Incision Time since surgery start time is in the second priority.

Notes for Abstraction: **continued**	Example #2: If documentation of 15:10 for anesthesia start time and 15:20 for operating room start time are found in the medical record, abstract 15:10 for the data element Cesarean Section Incision Time since this is the earliest time found within the fourth priority, anesthesia time.
	00:00 = midnight.
	If the time of initial incision is unable to be determined from medical record documentation, enter "UTD".
Suggested Data Sources:	Anesthesia record Circulation record Nursing notes Operative report Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Cesarean Section Start Date

Collected For: MAT-2a

Definition: The date (month, day, and year) the Cesarean section procedure started.

**Suggested Data
Collection Question:** On what date did the Cesarean section procedure start?

Format:

Length:		10 – MM-DD-YYYY (includes dashes) *or UTD*
Type:		Date
Occurs:		1

Allowable Values:

MM	=	Month (01-12)
DD	=	Day (01-31)
YYYY	=	Year (2000 – 9999)
UTD	=	Unable to Determine

Notes for Abstraction: If the date the Cesarean section procedure was started is unable to be determined from medical record documentation, enter "UTD".

If the Cesarean Section Start Date begins prior to midnight (day 1) and the incision time occurs after midnight (day 2), document the Cesarean Section Start Date as the date of the incision or day 2.
Example: If patient Cesarean Section Start Date falls on Jan 1 at 11:55pm and the incision is not made until Jan 2 at 00:30am, then the abstractor should enter the Cesarean Section Start Date as Jan 2.

Suggested Data Sources: Anesthesia record
Circulation record
Nursing notes
Operative report
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Clinical Trial

Collected For: All MassHealth Records

Definition: Documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.

**Suggested Data
Collection Question:** During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) There is documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.

N (No) There is no documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied, or unable to determine from medical record documentation.

Notes for Abstraction: Clinical trials are organized studies to provide large bodies of clinical data for strategically valid evaluation or treatment. These studies are usually rigorously controlled tests of new drugs, invasive medical devices, or therapies on human subjects.

To select "Yes" to this data element, BOTH of the following must be true:
1. There must be a signed consent form for clinical trial.
2. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.

Select "No" for this data element if the signed consent form is for an observational study only, it is not clear whether the study described in the signed consent form is experimental or observational, or it is not clear which study population the clinical trial is enrolling.

Suggested Data Sources: **ONLY ACCEPTABLE SOURCES:**
- Signed consent form for clinical trial

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Contact Information 24hrs/ 7 days

Collected For: CCM-2

Definition: Contact information _24hrs/ 7 days_ refers to any phone number that is listed for the patient to call for questions, concerns, or emergencies that is answered 24 hours a day, 7 days a week.

A transition record that included documentation on 24 hr/ 7 day Contact Information for _questions, concerns, or_ emergencies related to the inpatient stay.

**Suggested Data
Collection Question:**   Does the Transition Record include 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes)   The transition record includes 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay.

N (No)   The transition record does not include 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay.

Notes for Abstraction: Any number listed that is answered 24 hours a day, 7 days a week.

Must be clear to the patient that this is the number to call for questions, concerns, or emergencies.

Examples:
- For any questions, please call your PCP at …
- 24/7 Contact Information: Emergency Department phone number is ＿＿＿＿
- _Call 911 if chest pain_

In the event the patient is transferred to another site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site of care.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
- Call 911 - Emergency Room Phone Number - Primary Care Physician Phone Number - Specialist Phone Number - Discharging Unit Phone Number - Hospital phone number	

Data Element Name: Contact Information for Studies Pending at Discharge

Collected For: CCM-2

Definition: Contact information for studies pending refers to the name and/or phone number of a contact person that will provide information on tests when results are pending at discharge.

A transition record that included Contact Information for obtaining results of studies pending at discharge.

Suggested Data Collection Question: Does the Transition Record include Contact Information for obtaining results of studies pending at discharge?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) The transition record includes Contact Information for Studies Pending at Discharge or documentation *that there were* no studies pending at discharge.

N (No) The transition record does not include Contact Information for Studies Pending at Discharge or documentation *that there were* no studies pending at discharge.

Notes for Abstraction: If it is documented on the Transition Record that there were no studies pending at discharge, contact information for studies pending is not required and the abstractor should select Y(Yes).

Statements such as "Contact the Follow-up Physician listed above for any pending test results" will be accepted as long as the physician's name and/or phone number are documented on the transition record.
"Dr Jackson will discuss pending test results at your follow up appointment" will be accepted.
"MD to discuss at next visit" will NOT be accepted.

See also data element Studies Pending at Discharge

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Primary Care Physician • Name of Next Provider or Site of Care • Specialist Office • HIM/ Medical Records Department if phone number is provided	

Data Element Name:	Current Medication List
Collected For:	CCM-2
Definition:	A Current Medication List *is a list of* all medications (continued and new) to be taken by the patient after discharge.
	A transition record that included a Current Medication List given to the patient at the time of inpatient discharge.
Suggested Data Collection Question:	Does the Transition Record include a Current Medication List?
Format:	**Length:** 1
	Type: Alphanumeric
	Occurs: 1

Allowable Values:

Y (Yes)   The Transition Record includes a current medication list at the time of discharge *or documentation of no medications.*

N (No)   The Transition Record does not include a current medication list at the time of discharge *or documentation of no medications*.

Notes for Abstraction: *If there are no current medications, there must be documentation of "none" or "N/A".*

Suggested Data Sources: Transition Record
Discharge Instructions
Discharge Medication Reconciliation Form

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name:	Delivery Date

Collected For:	MAT-1

Definition: The month, day, and year the baby was delivered.

The Delivery Date cannot be before the Admission Date or after the Discharge Date.

Suggested Data Collection Question: On what date was the infant delivered?

Format:	**Length:**	10 – MM-DD-YYYY (includes dashes) *or UTD*
	Type:	Date
	Occurs:	1

Allowable Values:	MM	=	Month (0-12)
	DD	=	Day (01-31)
	YYYY	=	Year (2000 – 9999)
	UTD	=	Unable to Determine

Notes for Abstraction: If there are multiple births, abstract data on the infant born first.

If the delivery date is unable to be determined from medical record documentation, enter "UTD".

Suggested Data Sources: Birth Certificate
Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Nursing notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Delivery Time
Collected For:	MAT-1
Definition:	The time (military time) the baby was delivered.
Suggested Data Collection Question:	At what time was the infant delivered?

Format:

Length:	5 – HH:MM (with or without colon) *or UTD*	
Type:	Time	
Occurs:	1	

Allowable Values:

HH	=	Hour (00-23)
MM	=	Minutes (00-59)
UTD	=	Unable to Determine

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

	Correct Entry			Correct Entry
Midnight =	00:00	Noon =		12:00
5:31 am =	05:31	5:31 pm =		17:31
11:59 am =	11:59	11:59 pm =		23:59

Notes for Abstraction:

If there are multiple births;
    abstract data on the infant born first for MAT-1.

00:00 = midnight.

If the time of delivery is unable to be determined from medical record documentation, enter "UTD".

If multiple delivery times are documented in the medical record:
- abstract the earliest time for MAT-1

Suggested Data Sources:

Birth Certificate
Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Nursing notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Discharge Date
Collected For:	All MassHealth Records
Definition:	The month, day, and year the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.
Suggested Data Collection Question:	What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay?

Format:

Length:		10 – MM-DD-YYYY (includes dashes)
Type:		Date
Occurs:		1

Allowable Values:

MM	=	Month (01-12)
DD	=	Day (01-31)
YYYY	=	Year (2000 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

Suggested Data Sources: Discharge summary
Face sheet
Nursing discharge notes
Physician orders
Progress notes
Transfer note

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Discharge Diagnosis

Collected For: CCM-2

Definition: The discharge diagnosis is defined as the diagnosis determined at discharge,after procedures and tests were administered, to be chiefly responsible for resulting in the patient being admitted for inpatient hospital care.

A transition record that included the Discharge Diagnosis.

**Suggested Data
Collection Question:**   Does the Transition Record include the Discharge Diagnosis?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes)   The transition record includes the Discharge Diagnosis.

N (No)   The transition record does not include the Discharge Diagnosis.

Notes for Abstraction: The discharge diagnosis must be specifically documented as the discharge diagnosis and differentiated from the Reason for Inpatient Admission.

Discharge instructions with a title of the patient's condition does not meet the requirement for documentation of the patient's discharge diagnosis. Examples: Postpartum discharge instructions, Knee Replacement discharge instructions.

If the admission and discharge diagnosis are the same, documentation of "Same" for the discharge diagnosis will be accepted. The abstractor should select Y (Yes).   For example, a patient's admission diagnosis is pneumonia and the discharge diagnosis is pneumonia.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Discharge diagnosis • Final diagnosis • Primary diagnosis at discharge • Principal diagnosis • Working diagnosis	Post-op diagnosis Secondary diagnosis

Data Element Name: Discharge Disposition

Collected For: All MassHealth Records

Definition: The final place or setting to which the patient was discharged on the day of discharge.

**Suggested Data
Collection Question:** What was the patient's discharge disposition on the day of discharge?

Format: **Length:**   1
           Type: Alphanumeric
           Occurs: 1

Allowable Values: 1   Home

                2   Hospice- Home

                3   Hospice- Health Care Facility.

                4   Acute Care Facility

                5   Other Health Care Facility

                6   Expired

                7   Left Against Medical Advice / AMA

                8   Not Documented or Unable to Determine (UTD)

Notes for Abstraction:

● Only use documentation from the day of or the day before discharge when abstracting this data element.
Example:
Documentation in the discharge planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value "5".
● Consider discharge disposition documentation in the discharge summary or a post-discharge addendum as day of discharge documentation, regardless of when it was dictated/written.
● *The medical record must be abstracted as documented (taken at "face value"). Inferences should not be made based on internal knowledge.*
● *If there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract, If documentation is contradictory, use the latest documentation.*
Example:
   o *Discharge summary dictated 2 days after discharge states patient went "home". Physician note on day of discharge further clarifies that the patient will be going "home with hospice". Select value "2"(Hospice-Home)*
   o *Discharge planner note from day before discharge states "XYZ Nursing Home". Discharge order from day of discharge states "Discharge home". Contradictory documentation, use latest. Select value "1"(Home).*

o *Physician order on discharge states "Discharge to ALF". Discharge instruction sheet completed after physician order states patient discharged to "SNF". Contradictory documentation, use latest. Select value "5" (Other Health Care Facility).*

- If documentation is contradictory, ~~use~~ *and you are unable to determine* the latest documentation, *select the disposition ranked highest (top to bottom) in the following list. See inclusion lists for examples.*
    - o *Acute Care Facility*
    - o *Hospice-Health Care Facility*
    - o *Hospice-Home*
    - o *Other Health Care Facility*
    - o *Home*
- *Hospice (values "2" and "3") includes discharges with hospice referrals and evaluations.*
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value "4".
- *If the medical record identifies the facility the patient is being discharged to by name only (e.g., "Park Meadows"), and does not reflect the type of facility or level of care, select value "5" (Other Health Care Facility).*
- *If the medical record states only that the patient is being "discharged" and does not address the place or setting to which the patient was discharged, select value "1" (Home).*
- *When determining whether to select value "7" (Left Against Medical Advice/ AMA):*
    - o *Explicit "left against medical advice" documentation is not required. E.g., "Patient is refusing to stay for continued care"- Select value "7".*
    - o *Documentation suggesting that the patient left before discharge instructions could be given does not count.*
    - o *A signed AMA form is not required for the purposes of this data element.*
    - o *Do not consider AMA documentation and other disposition documentation as "contradictory". If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states "Discharged home with belongings"- Select "7".*

Suggested Data Sources: Discharge instruction sheet
Discharge planning notes
Discharge summary
Nursing discharge notes
Physician orders
Progress notes
Social service notes
Transfer record

Excluded Data Source: Any documentation prior to the *last two days of hospitalization.*

Guidelines for Abstraction:

Inclusion	Exclusion
For Value 1: • Assisted Living Facilities (ALFs)- *includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities* • Court/Law Enforcement- includes detention facilities, jails, prison • Home- includes board and care, foster or residential care, group or personal care homes,	*None*

retirement communities, and homeless shelters • Home with Home Health Services • Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization *For Value 2:* • *Hospice in the home (or other "Home" setting as above in Value 1)* For Value 3: • Hospice Care- General Inpatient and Respite • Hospice Care- Residential and Skilled Facilities • Hospice Care- Other Health Care Facilities (excludes home) For Value 4: • Acute Short Term General and Critical Access Hospitals • Cancer and Children's Hospitals • Department of Defense and Veteran's Administration Hospitals For Value 5: • Extended or Immediate Care Facility (ECF/ICF) • Long Term Acute Care Hospital (LTACH) • Nursing Home or Facility including Veteran's Administration Nursing Facility • Psychiatric Hospital or Psychiatric Unit of a Hospital • Rehabilitation Facility including Inpatient Rehabilitation Facility/ Hospital or Rehabilitation Unit of a Hospital • Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed • Transitional Care Unit (TCU)	

Data Element Name:	Episode of Care
Collected For:	All MassHealth Records
Definition:	The measure code for the data that is being submitted.
Suggested Data Collection Question:	What is the measure code for the data being submitted?

Format: **Length:** 22
   Type: Alphanumeric
   Occurs: 1

Allowable Values:

CAC	Children's Asthma Care (includes CAC 1a, 2a and 3)
CCM	Care Coordination (includes CCM-1, CCM-2, & CCM-3)
ED	Emergency Department Times for admitted patients
MAT-1	Intrapartum Antibiotic Prophylaxis for GBS
MAT-2	Perioperative Antibiotics for Cesarean Section (includes MAT-2a and MAT-2b)
MAT-3	Elective Delivery
PN	Community Acquired Pneumonia
SCIP	Surgical Care Infection Prevention

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Ethnicity

Collected For: All MassHealth Records

Definition: The patient's self-reported ethnicity as defined by Massachusetts _regulation noted in Section 2 of this EOHHS manual._

The definition of the "Ethnicity" data element differs from the CMS National Hospital Inpatient Quality Measures reporting requirement.

**Suggested Data
Collection Question:** What is the patient's self-reported ethnicity?

Format:

Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values: Select one:

CODE	Allowable Value	CODE	Allowable Value
2060-2	African**	2071-9	Haitian
2058-6	African American	2158-4	Honduran
AMERCN	American	2039-6	Japanese
2028-9	Asian**	2040-4	Korean
2029-7	Asian Indian	2041-2	Laotian
BRAZIL	Brazilian	2148-5**	Mexican, Mexican American, Chicano
2033-9	Cambodian	2118-8**	Middle Eastern
CVERDN	Cape Verdean	PORTUG**	Portuguese
CARIBI	Caribbean Island	2180-8	Puerto Rican
2034-7	Chinese	RUSSIA	Russian
2169-1	Columbian	2161-8	Salvadoran
2182-4	Cuban	2047-9	Vietnamese
2184-0	Dominican	2155-0**	Central American (not specified)
EASTEU	Eastern European**	2165-9**	South American (not specified)
2108-9	European**	OTHER	Other Ethnicity
2036-2	Filipino	UNKNOW	Unknown/not specified
2157-6	Guatemalan		

**Refer to Table 2.4 in Section 2 of this EOHHS manual for additional ethnicity subcategories that apply to these codes.

Notes for Abstraction:
As noted in Section 2, Table 2.3 comparison chart, the Massachusetts regulation provides a broader mapping of Ethnicity Hierarchy codes and allowable values not required by CMS hospital quality reporting. Hospitals must use the *Massachusetts regulation* Ethnicity codes and allowable values when preparing all MassHealth data files for submission.

Only collect ethnicity data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.

The terms "nationality" and "culture" are synonymous to ethnicity.

If numeric code is used, include the hyphen after the fourth number.

If the medical record contains conflicting documentation on patient self-reported ethnicity, abstract the most recent dated documentation. If the medical record contains multiple patient self-reported ethnicities on one document, abstract the first self-reported ethnicity listed (e.g. – American/Irish/French, select American).

If the medical record contains 1) self reported as Unknown or 2) no ethnicity can be found in the medical record, select "UNKNOW".

If the ethnicity documented in the medical record is not listed in any of the allowable values *in Section 2, Table 2.4*, select "OTHER".

If codes and allowable values, other than those listed above, are documented in the medical record, a crosswalk that links the hospitals' codes/values to the *Massachusetts regulation* requirements must be provided for chart validation.

Suggested Data Sources:
Administrative record
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: First Name

Collected For: All MassHealth Records

Definition: The patient's first name.

**Suggested Data
Collection Question:**   What is the patient's first name?

Format: **Length:**   30
      Type: Alphanumeric
      Occurs: 1

Allowable Values: Enter the patient's first name.

Notes for Abstraction: None

Suggested Data Sources: Emergency department record
      Face sheet
      History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	GBS Bacteriuria
Collected For:	MAT-1
Definition:	Documentation that the mother had GBS bacteriuria at any time during this pregnancy. GBS bacteriuria is defined as the presence of any GBS reported on a urine culture (not a vaginal/rectal culture).
Suggested Data Collection Question:	Is there documentation that the mother had GBS bacteriuria at any time during this pregnancy?

Format:

	Length:	1
	Type:	Alphanumeric
	Occurs:	1

Allowable Values:

Y (Yes)   There is documentation that the mother had GBS bacteriuria at any time during this pregnancy.

N (No)   There is no documentation that the mother had GBS bacteriuria at any time during this pregnancy or unable to determine from medical record documentation.

Notes for Abstraction: GBS bacteriuria must be documented for the current pregnancy.

A urinary tract infection during pregnancy is not necessarily GBS. There must be documentation of GBS bacteriuria to select Y(Yes).

Suggested Data Sources: History and physical
Lab reports
Pre-natal record
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	GBS Screening

Collected For:	MAT-1

Definition:	Documentation of results of the mother's vaginal and rectal screening culture for GBS performed at 35 weeks 0 days – 37 weeks 6 days gestation or within 5 weeks prior to birth.

Suggested Data Collection Question:	What is the result of the mother's vaginal and rectal screening culture for GBS performed at 35 weeks 0 days – 37 weeks 6 days or within 5 weeks prior to birth?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

P   Positive: there is documentation that the mother's vaginal and rectal screening culture for GBS performed at 35 weeks 0 days – 37 weeks 6 days gestation or within 5 weeks prior to birth was positive.

N   Negative: there is documentation that the mother's vaginal and rectal screening culture for GBS performed at 35 weeks 0 days – 37 weeks 6 days gestation or within 5 weeks prior to birth was negative.

U   Unknown / Unable to Determine or not performed within specified time frame

Notes for Abstraction: Documentation must indicate that the screening culture was performed between the 35th and 37th week (35 weeks 0 days – 37 weeks 6 days) of pregnancy or within 5 weeks prior to birth, if not, select U "Unknown/ Unable to Determine".

If the GBS vaginal and rectal screening culture results are documented, but there is no documentation as to when the culture was performed, select U "Unknown/ Unable to Determine".

Suggested Data Sources: Delivery note
History and physical
Lab reports
Labor and delivery flow sheets
Labor and delivery summary
Prenatal record
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Gestational Age
Collected For:	MAT-1, MAT-3
Definition:	The gestational age of the infant in completed weeks at the time of delivery.
	Gestational age is defined as the number of weeks that have elapsed between the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery, irrespective of whether gestation results in a live birth or fetal death.
Suggested Data Collection Question:	What was the infant's gestational age at the time of delivery?

Format:

Length:	3 or UTD
Type:	Alphanumeric
Occurs:	1

Allowable Values:

In completed weeks
No leading zero
UTD

Notes for Abstraction:

Use completed weeks of gestation, do not "round up". For example, an infant born at 35 weeks 6 days is at a gestational age of 35 weeks.

The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical; prenatal forms; clinician admission progress note and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

If the patient has not received prenatal care, and the gestational age is unknown, select allowable value UTD.

When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date.

Gestational age should be documented by the clinician as a numeric value between 1-50. The clinician, not the abstractor, should perform the calculation to determine gestational age based on the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery.

If the gestational age entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered.

Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).

It is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their

accuracy. If this is the care, these may be used in lieu of the acceptable data sources listed below.

Suggested Data Sources: ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE

- Delivery room record
- Operating room record
- History and physical
- Prenatal forms
- Admission clinician progress notes
- Discharge summary

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Gestational Age < 37 Weeks
Collected For:	MAT-1
Definition:	A gestational age at the time of delivery less than 37 weeks.
Suggested Data Collection Question:	Is there documentation that the gestational age of the infant at the time of delivery was less than 37 weeks?

Format:

	Length:	1
	Type:	Alphanumeric
	Occurs:	1

Allowable Values:

Y (Yes)   There is documentation that the gestational age of the infant at the time of delivery was less than 37 weeks.

N (No)   There is no documentation that the gestational age of the infant at the time of delivery was less than 37 weeks or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:
Delivery note
History and physical
Labor and delivery flow sheets
Labor and delivery summary
Progress notes
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Hispanic Indicator
Collected For:	All MassHealth Records
Definition:	The patient self-reported as Hispanic, Latino, or Spanish *as defined by Massachusetts regulation noted in Section 2 of this EOHHS manual.*
	The definition of the "Hispanic" data element in the Massachusetts regulation differs from the CMS National Hospital Inpatient Quality Measures reporting requirement.

**Suggested Data
Collection Question:**   Is there documentation that the patient self-reported as Hispanic, Latino, or Spanish?

Format: **Length:**   1
       Type: Alphanumeric
       Occurs: 1

Allowable Values: Y (Yes)   Patient self-reported as Hispanic / Latino / Spanish.

                       N (No)   Patient did not self-report as Hispanic / Latino / Spanish or unable to determine from medical record documentation.

Notes for Abstraction: *As noted in Section 2, Table 2.3 comparison chart, the Massachusetts regulation valid entry codes and allowable values for the "Hispanic" data element differs from CMS reporting requirement.* Hospitals must use the *Massachusetts regulation* definition and allowable values when preparing all MassHealth data files for submission.

Only collect data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.

If the medical record contains conflicting documentation on patient self-reported Hispanic Indicator, abstract the most recent dated documentation. If the patient's self-reported Race is Hispanic, abstract "Yes" for Hispanic Indicator.

Suggested Data Sources: Administrative records
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusion	Exclusion
The term "Hispanic" or "Latino" can be used in addition to "Spanish origin" to include a person of Spanish culture or origin regardless of race.	None

Data Element Name: Hospital Bill Number

Collected For: All MassHealth Records

Definition: The *definition of the hospital bill number (or account number) is the* unique number assigned to each patient's bill that distinguishes the patient and their bill from all others in that institution as defined by Massachusetts *regulation noted in Section 2 of this EOHHS manual.*

**Suggested Data
Collection Question:** What is the patient's hospital bill number?

Format:

Length:	20	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values: Up to 20 letters and/ or numbers

Notes for Abstraction: None

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
• *Account Number* • *Bill Number*	

Data Element Name:	ICD-9-CM Other Diagnosis Codes
Collected For:	All MassHealth Records
Definition:	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.
Suggested Data Collection Question:	What were the ICD-9-CM other diagnosis codes selected for this medical record?

Format:

Length:	6 (with or without decimal point)	
Type:	Alphanumeric	
Occurs:	24	

Allowable Values:	Any valid ICD-9-CM diagnosis code
Notes for Abstraction:	None
Suggested Data Sources:	Discharge summary Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-9-CM Other Procedure Codes

Collected For: All MassHealth Records

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes identifying all significant procedures other than the principal procedure.

**Suggested Data
Collection Question:** What were the ICD-9-CM code(s) selected as other procedure(s) for this record?

Format:

Length:	5 (with or without decimal point)	
Type:	Alphanumeric	
Occurs:	24	

Allowable Values: Any valid ICD-9-CM diagnosis code

Notes for Abstraction: None

Suggested Data Sources: Discharge summary
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	ICD-9-CM Other Procedure Dates
Collected For:	All MassHealth Records
Definition:	The month, day, and year when the associated procedure(s) was (were) performed.
Suggested Data Collection Question:	What were the date(s) the other procedure(s) were performed?

Format:

Length:	10 – MM-DD-YYYY (included dashed) or UTD
Type:	Date
Occurs:	24

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001 – Current Year)
UTD = Unable to Determine

Notes for Abstraction:

- If the procedure date for the associated procedure is unable to be determined from the medical record, select "UTD".
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not valid format/range or outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Examples:
  - Documentation indicates the *ICD-9-CM Other Procedure Dates* was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Other Procedure Dates* is outside of the range listed in the Allowable Values for "Day", It is not a valid date and the abstractor should select "UTD"
  - Patient expires on 02-12-20xx and documentation indicates the ICD-9-CM Other Procedure Dates was 03-12-20xx. Other documentation in the medical records supports the date of death as being accurate. Since the *ICD-9-CM Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters of care and abstractor should select "UTD"

  Notes: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ICD-9-CM Other Procedure Dates* allows the case to be accepted in the warehouse

Suggested Data Sources:

Consultation notes
Diagnostic test reports
Discharge summary
Face sheet
Operative notes
Procedure notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	ICD-9-CM Principal Diagnosis Code
Collected For:	All MassHealth Records
Definition:	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.
Suggested Data Collection Question:	What was the ICD-9-CM code selected as the principal diagnosis for this record?

Format:

Length:	6 (with or without decimal point)	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values:	Any valid ICD-9-CM diagnosis code
Notes for Abstraction:	The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
Suggested Data Sources:	Discharge summary Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	ICD-9-CM Principal Procedure Code
Collected For:	All MassHealth Records
Definition:	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.
Suggested Data Collection Question:	What was the ICD-9-CM code selected as the principal procedure for this record?

Format:

	Length:	5 (with or without decimal point)
	Type:	Alphanumeric
	Occurs:	1

Allowable Values:	Any valid ICD-9-CM diagnosis code
Notes for Abstraction:	The principal procedure as described by the Uniform Hospital Discharge Data Set (UHDDS) is one performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.
Suggested Data Sources:	Discharge summary Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	ICD-9-CM Principal Procedure Date
Collected For:	All MassHealth Records
Definition:	The month, day, and year when the principal procedure was performed.
Suggested Data Collection Question:	What was the date the principal procedure was performed?

Format: **Length:** 10-MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values: MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction: If the principal procedure date is unable to be determined from medical record documentation, select "UTD"

The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not valid date/format or is outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD"
Examples:
- Documentation indicates the *ICD-9-CM Principal Procedure Date* was 02-42-20xx. No other documentation n the medical record provides a valid date. Since the *ICD-9- CM Principal Procedure Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD"
- Patient expires on 02-12-20xx and documentation indicates the *ICD-9-CM Principal Procedure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Principal Procedure Date* is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select "UTD".

Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ICD-9-CM Principal Procedure Dat*e allows the case to be accepted into the warehouse.

Suggested Data Sources: Consultation notes
Diagnostic test reports
Discharge summary
Face sheet
Operative notes
Procedure notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Infection Prior to Cesarean Section
Collected For:	MAT-2a and MAT-2b
Definition:	Documentation the patient had, or was suspected to have, an infection during this hospitalization prior to the Cesarean section procedure or that the patient's amniotic membranes were ruptured for 18 or more hours.
Suggested Data Collection Question:	Is there documentation that the patient had a confirmed or suspected infection during this hospitalization prior to the Cesarean section or that the patient's amniotic membranes were ruptured for 18 or more hours?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) — There is physician / advanced practice nurse (APN)/ physician assistant (PA) documentation that the patient had a confirmed or suspected infection during this hospitalization prior to the Cesarean section procedure or that the patient's amniotic membranes were ruptured for 18 or more hours.

N (No) — There is no physician / APN / PA documentation that the patient had a confirmed or suspected infection during this hospitalization prior to the Cesarean section procedure or that the patient's amniotic membranes were ruptured for 18 or more hours, or unable to determine from medical record documentation.

Notes for Abstraction:

If there is documentation of an infection or possible / suspected infection, select "Yes."

If there is documentation the amniotic membranes were ruptured for 18 or more hours, select "Yes."

Documentation of symptoms (example: fever, elevated white blood cells, etc.) should not be considered infections unless documented as an infection or possible/suspected infection.

If a patient has a principal ICD-9-CM diagnosis code suggestive of pre-operative infectious diseases (as defined in Appendix A Table 5.09 of the Specifications Manual for National Hospital Inpatient Quality Measures) the abstractor should select Y(Yes).

A positive result on GBS Screening is not evidence of infection.

Documentation of suspected or confirmed chorioamnionitis, select Y(Yes).

Suggested Data Sources:
Anesthesia record
History and physical
Progress notes

Guidelines for Abstraction:

Inclusions	Exclusions
Refer to Appendix A, Table 5.09 in the appropriate version of the Specifications Manual for National Hospital Inpatient Quality Measures.	Colonized MRSA History (Hx) of MRSA Viral infections

Data Element Name:	Intrapartum Antibiotics

Collected For:	MAT-1

Definition:	Documentation the patient received IV antibiotics for GBS prophylaxis in the intrapartum period.

Suggested Data Collection Question:	Is there documentation that the patient received IV antibiotics for GBS prophylaxis in the intrapartum period?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)   There is documentation that the patient received IV antibiotics for GBS prophylaxis in the intrapartum period.

N (No)   There is no documentation that the patient received IV antibiotics for GBS prophylaxis in the intrapartum period or unable to determine from medical record documentation.

Notes for Abstraction: Intrapartum is defined as during labor and delivery or childbirth.

Suggested Data Sources: Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Medication administration record (MAR)
Physician notes
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Intrapartum Temperature

Collected For: MAT-1

Definition: Documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C).

**Suggested Data
Collection Question:**   Is there documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C)?

Format:

Length:	1	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values:

Y (Yes)   There is documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C).

N (No)   There is no documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C) or unable to determine from medical record documentation.

Notes for Abstraction: Intrapartum is defined as during labor and delivery or childbirth.

Suggested Data Sources: History and physical
Labor and delivery flow sheet
Physician notes
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	IV Antibiotic for Cesarean Section Prophylaxis
Collected For:	MAT-2a and MAT-2b
Definition:	Documentation the patient received an IV antibiotic for Cesarean section prophylaxis.
Suggested Data Collection Question:	Is there documentation that the patient received an IV antibiotic for Cesarean section surgical prophylaxis?

Format:

Length:	1	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values:

Y (Yes)	There is documentation that the patient received an IV antibiotic for Cesarean section surgical prophylaxis.
N (No)	There is no documentation that the patient received an IV antibiotic for Cesarean section surgical prophylaxis or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:
Anesthesia record
IV flowsheet
Medication administration record (MAR)
Nursing notes
Operating room record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	IV Antibiotic (Non-GBS) – MAT-1

Collected For:	MAT-1

Definition:	Documentation the patient received an intravenous (IV) antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery.

Suggested Data Collection Question:	Is there documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery?

Format:	**Length:**	1
	Type:	Alphanumeric
	Occurs:	1

Allowable Values:	Y (Yes)	There is documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery.
	N (No)	There is no documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery or unable to determine from medical record documentation.

Notes for Abstraction:	This question refers to IV antibiotics administered for reasons other than GBS or Cesarean section prophylaxis. The reason can be documented or undocumented. A physician order alone is not sufficient to abstract this data, there must also be documentation that the medication was administered. Do not select "Yes" for intravenous antibiotics administered prior to the birth admission.

Suggested Data Sources:	Discharge summary History and physical Medication administration record (MAR) Physician notes Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	IV Antibiotic (Non-GBS) – MAT-2a,2b
Collected For:	MAT-2a and MAT-2b

Definition: Documentation the patient received an intravenous (IV) antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time.

Suggested Data Collection Question: Is there documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes) There is documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time.

N (No) There is no documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time or unable to determine from medical record documentation.

Notes for Abstraction: This question refers to IV antibiotics administered for reasons other than GBS or Cesarean section prophylaxis. The reason can be documented or undocumented.

A physician order alone is not sufficient to abstract this data, there must also be documentation that the medication was administered.

Do not select "Yes" for intravenous antibiotics administered prior to the birth admission.

Suggested Data Sources: Discharge summary
History and physical
Medication administration record (MAR)
Physician notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Labor
Collected For:	MAT-3
Definition:	Documentation by the clinician that the patient was in labor.
Suggested Data Collection Question:	Is there documentation that the patient was in labor?

Format:	**Length:**	1
	Type:	Alphanumeric
	Occurs:	1

Allowable Values: Y (Yes) There is documentation that the patient was in labor.

N (No) There is no documentation that the patient was in labor OR unable to determine from medical record documentation.

Notes for Abstraction: A clinician is defined as a physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).

Suggested Data Sources: History and physical
Nursing Notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
• Active labor • *Early Labor* • Spontaneous labor	• *Latent Labor* • Prodromal labor

Data Element Name: Last Name

Collected For: All MassHealth Records

Definition: The patient's last name.

**Suggested Data
Collection Question:**   What is the patient's last name?

Format:

Length:	60	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values: Enter the patient's last name.

Notes for Abstraction: None

Suggested Data Sources: Emergency department record
Face sheet
History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Live Newborn

Collected For: MAT-1

Definition: Documentation the baby delivered was born alive

**Suggested Data
Collection Question:**   Is there documentation that the mother delivered a live newborn?

Format: **Length:**   1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes)   There is documentation that the mother delivered a live newborn.

N (No)   There is documentation that the mother *did not* deliver a live newborn or unable to determine from medical record documentation.

Notes for Abstraction: In cases of multiple births and one infant is born alive, select "Yes".

For deliveries resulting in stillbirths identified by ICD-9-CM principal and secondary diagnosis codes of V27.1, V27.3, V27.4, V27.6, V27.7, the abstractor may select N(No).

Suggested Data Sources: Birth certificate
Delivery note
Discharge summary
Nurses notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: MassHealth Member ID

Collected For: All MassHealth Records

Definition: The patient's MassHealth Member ID.

**Suggested Data
Collection Question:**   What is the patient's MassHealth Member ID?

Format:

Length:	20	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values: Any valid MassHealth Member ID number
Alpha characters must be upper case
No embedded dashes or spaces or special characters

Notes for Abstraction: The Provider Regulations define a valid MassHealth Member ID as a twelve (12) digit number that contains numeric characters only. This 12 digit member ID number applies to members enrolled within various Medicaid managed care or fee-for-service insurance programs.

However, some MassHealth managed care insurance plans may issue different MassHealth member ID numbers that use alphanumeric type and exceed the 12 digit numeric requirement. For the purposes of measures reporting the "format length" was expanded to 20 fields within the portal environment only. This portal edit allows data files that may exceed the 12 characters to not be rejected by the portal. The change in the portal environment **does not** constitute a change to existing MassHealth Provider Regulation definitions of member ID number.

Once a member is assigned a MassHealth ID number it will not change through the duration of their enrollment or if they change managed care plans (e.g.: coverage changed from fee-for-service to an MCO plan).Member ID numbers can be verified using the on-line Eligibility Verification System (EVS) at:

http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/eligibility-verification/. EVS provides historical data on a member for any given point in time that can be reviewed by entering a particular date of service.

The abstractor should NOT assume that their hospital's claim information for the patient's MassHealth Member ID number is correct. If the abstractor determines through chart review that the MassHealth Member ID number is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.

Suggested Data Sources: Emergency department record
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Maternal Allergies
Collected For:	MAT-1, MAT-2b
Definition:	Documentation the patient has an allergy, sensitivity, or intolerance to any of the recommended antibiotic classes for this measure. An allergy can be defined as an acquired, abnormal immune response to a substance (allergen) that does not normally cause a reaction.
Suggested Data Collection Question:	Is there documentation that the patient has allergies, sensitivities, or intolerances to any of the recommended antibiotic classes for this measure?

Format:	**Length:**	1
	Type:	Alphanumeric
	Occurs:	1

Allowable Values:	Y (Yes)	There is documentation that the patient has an allergy, sensitivity, or intolerance to any of the recommended antibiotic classes for this measure**.**
	N (No)	There is no documentation that the patient has an allergy, sensitivity, or intolerance to any of the recommended antibiotic classes for this measure or unable to determine from medical record documentation.

Notes for Abstraction: This question should only be answered if "Other" was selected as the prophylactic antibiotic.

If a physician/advanced practice nurse/physician assistant (physician/APN/PA) documents a specific reason(s) not to give any of the recommended antibiotic classes for this measure, select "Yes."

The antibiotic classes include:
MAT-1: Penicillins/Beta lactams, cephalosporins, lincosamides, or glycopeptides.

MAT-2b: Penicillins/Beta lactams, cephalosporins, or aminoglycosides.

Suggested Data Sources: Consultation notes
History and physical
Medication administration record (MAR)
Nursing admission assessment
Nursing notes
Physician orders
Progress notes

Guidelines for Abstraction:

Inclusions	Exclusion
Symptoms include: Adverse effect Adverse reaction Anaphylaxis Anaphylactic reaction Hives Rash	None

Data Element Name:	Medical Procedures and Tests & Summary of Results
Collected For:	CCM-2

Definition: Medical procedures and tests performed refer to *procedures and tests* performed during the acute inpatient hospitalization to help establish the diagnosis at discharge and course of treatment. Summary of results refers to the *results of the* medical procedures and tests performed.

A transition record includes the Medical Procedures and Tests that were significant and relevant to the care of the patient performed during inpatient stay and a Summary of Results.

Suggested Data Collection Question: Does the Transition Record include the Medical Procedure(s) and Test(s) and a Summary of Results?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)   The transition record includes the Medical Procedure(s) and Test(s) and a Summary of Results or documentation of No Procedures and Tests.

N (No)   The transition record does not include the Medical Procedure(s) and Test(s) and a Summary of Results or documentation of No Procedures and Tests.

Notes for Abstraction: Hospitals determine which procedures or tests are relevant to the care of the specific patient. Not all procedures and tests should be documented.

Some examples that will be accepted:

Procedures:	Tests
-C-section	-Urine Cultures
-Vaginal delivery	-Blood Cultures
-Appendectomy	-Imaging Studies (x-rays, CT scan)
-Heart cath with stent	
-Knee Replacement	

There must be a summary of results for each procedure or test documented. Exception: Surgical procedures documented do not require a summary of the results. Example: Appendectomy would not require a summary of the results.

Any reference to actual study results or summary results will answer Y (Yes). Example: "Echo results pending," "Abnormal results to be discussed with physician," "Within normal limits," "Complicated," "Abnormal," or the actual test results

If there is documentation of "No procedures or tests/ None/ N/A", the abstractor should select Y (Yes).

In the event of a transfer to another *site of care*, if copies of all medical procedures and tests performed during inpatient stay were *transmitted* with the patient to the receiving *site*, this element may be documented as Y (Yes). *Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.*

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
Normal/ Abnormal Within normal limits Results to be discussed with physician	

Data Element Name:	National Provider ID
Collected For:	All MassHealth Records
Definition:	The provider's ten digit national provider identifier.
Suggested Data Collection Question:	What is the provider's ten digit national provider identifier?

Format:

Length:	10	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values:	Any valid ten digit national provider ID.
Notes for Abstraction:	Hospitals must submit either their valid Medicare or Medicaid Provider ID or their National Provider ID for all MassHealth maternity measure files.
Suggested Data Sources:	Administrative record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Other Surgeries
Collected For:	MAT-2a and MAT-2b
Definition:	Other procedures requiring general or spinal/epidural anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay.
Suggested Data Collection Question:	Were there any other procedures requiring general or spinal anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation of another procedure requiring general or spinal/epidural anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay.
N (No)	There is no documentation of any other procedure requiring general or spinal/epidural anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay or unable to determine from medical record documentation.

Notes for Abstraction: The following are two scenarios that must be clarified:
- If multiple procedures are performed during the same surgical episode, select "No."
- If other procedures are performed during separate surgical episodes requiring general or spinal/epidural anesthesia and occur within three days of the principal procedure during this hospital stay, select "Yes."

Suggested Data Sources: Admitting physician orders
Admitting progress notes
Consultation notes
Discharge summary
Emergency department record
History and physical
Nursing notes
Operative notes/reports
Physician admission notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Patient Identifier

Collected For: All MassHealth Records

Definition: The identification number used by the Hospital to identify this patient.

**Suggested Data
Collection Question:**   What is the patient's hospital patient identification number?

Format: **Length:**   40
                Type: Alphanumeric
                Occurs: 1

Allowable Values: Up to 40 letters and / or numbers

Notes for Abstraction: When abstracting this data element for a clinical measure file, the data in this field must match the hospital patient ID number submitted in the corresponding crosswalk file.

Suggested Data Sources: Administrative record
                              Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Patient Instructions

Collected For: CCM-2

Definition: Patient Instructions refers to information that is associated with the diagnosis, treatment, and plan of care specific to the patient's inpatient stay that should be followed by the patient after discharge from inpatient care.

A transition record that included patient instructions (discharge instructions) related to the inpatient stay.

**Suggested Data
Collection Question:** Does the Transition Record include Patient Instructions?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes Patient Instructions.

N (No) The transition record does not include Patient Instructions.

Notes for Abstraction: Patient instructions include post-discharge patient self-management instructions.

If the patient instructions given to the patient are on a separate page from the transition record and not retained in the permanent medical record, there must be a reference listing the patient instructions given to the patient.

Patient instructions should be transmitted to the next provider of care with the Transition Record.

In the event the patient is transferred to another site where the patient instructions will be determined at the time of discharge from that site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site of care.

Suggested Data Sources: Transition Record
Patient Instructions (may be pre-printed forms)
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Payer Source
Collected For:	All MassHealth Records
Definition:	*The definition of Medicaid payer source as defined by the Massachusetts regulations noted in Section 2 of this EOHHS manual.*
	The definition of the Medicaid payer source data element differs from the CMS National Hospital Inpatient Quality Measures reporting requirement.
Suggested Data Collection Question:	What is the patient's primary source of Medicaid payment for care provided?

Format:

Length:	3	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values: Payment source code values assigned by *Massachusetts regulations* include:

- 103 Medicaid - includes MassHealth Fee-for-Service, and includes "MassHealth Limited"
- 104 Medicaid Managed Care – Primary Care Clinician (PCC) Plan
- 108 Medicaid Managed Care - Fallon Community Health Plan
- 110 Medicaid Managed Care – Health New England
- 113 Medicaid Managed Care – Neighborhood Health Plan
- 118 Medicaid Mental Health/Substance Abuse Plan- Mass Behavioral Health Partnership
- 207 Network Health - Cambridge Health Alliance MCD Program
- 208 HealthNet – Boston Medical Center MCD Program
- 119 Medicaid Managed Care Other (not listed elsewhere).This code is a catchall for other insurance products that existed or new products that may arise during a given time period. These products may be assigned different revenue codes by the hospital depending on how they use it.

- 98 Healthy Start Program. The Healthy Start Program (HSP) typically covers prenatal and postpartum care but not inpatient services. All HSP labor and delivery services are covered under MassHealth Limited (payer code 103). Hence payer code 98 would not be listed as a primary code.

  The MassHealth Eligibility Verification System (EVS) will show coverage type "Limited plus Healthy Start". Provider Bulletin # 204 (June 2010) contains details on HSP coverage posted on http://www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/provider-bulletins

- 178 Children's Medical Security Plan (CMSP)

Notes for Abstraction: *In Section 2 (Table 2.2) of this manual, the Massachusetts regulations outline the payer data element definitions and codes for Medicaid payment sources required when preparing MassHealth data files for submission.*

Primary source of payment is a MassHealth insurance program:
- If Medicaid is the only payer listed (see payer codes above);
- If Medicaid is primary and another secondary insurance is listed.

Primary source of payment is NOT a MassHealth insurance program:
- If Medicare is the only payer listed;
- If Medicare is primary and lists Medicaid as secondary(ex: dual eligible)
- If HMO/Commercial Plan is primary and lists Medicaid as secondary (TPL)

The Medicaid payer type and codes are based on the *Massachusetts Hospital case mix and discharge data (130 CMR 17.00) regulations as follows: http://www.mass.gov/chia/docs/g/chia-regs/114-1-17-payer-source-codes-2010.pdf*

Suggested Data Sources: Face sheet (Emergency Department / Inpatient)
UB-04, filed location, 50A, B, C
MassHealth Eligibility Verification System (EVS)
http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/eligibility-verification/

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Plan for Follow-up Care
Collected For:	CCM-2

Definition: Plan for Follow-up Care refers to a document that describes further action to be taken after the patient is discharged that is shared with patient/family caregiver. The purpose of a plan for follow-up care is to track and monitor progress toward patient goals.

A transition record that included a Plan for Follow-up Care related to the inpatient stay or documentation by a physician of no follow-up care required.

**Suggested Data
Collection Question:** Does the Transition Record include a Plan for Follow-up Care related to the inpatient stay OR documentation by a physician of no follow-up care required OR patient is a transfer to another *site of care*?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes)   The transition record includes a Plan for Follow-up Care OR documentation by a physician of no follow-up care required OR patient is a transfer to another *site of care*.

N (No)   The transition record does not include a Plan for Follow-up Care.

Notes for Abstraction: The Plan for follow-up care may include:
- Any post discharge therapy needed (ex. physical, occupational, home health visits, VNA)
- Any durable medical equipment needed
- Family psychosocial resources available for patient support *(ie. counseling, Alcoholics Anonymous)*, or
- Follow up appointments

A scheduled appointment or specific instructions for the patient to call within a certain timeframe to make an appointment with a specific physician/ health care professional will be accepted.
Example: Call Dr Jackson for appointment in 1 week
         Dr Jackson's office to call patient with appointment date/time
         Follow up with Dr Jackson as needed

If the patient does not have a primary care physician, then the patient can be referred to a healthcare clinic for follow up**.**

If it is documented that the patient has declined any plan for follow-up care OR a primary care provider or clinic cannot be identified, then the patient can be referred to the Emergency Department for emergent care.

In the event the patient is transferred to another *site of care* where the plan for follow-up care will be determined at the time of discharge from that *site,* this data element may be documented as Y(Yes). *Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.*

If it is determined and documented by the physician that the patient requires no follow-up care, documentation of this on the transition record will be acceptable and Y(Yes) should be selected.

Suggested Data Sources: Transition Record
                                   Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Instruction for patient to call specific physician / health care professional to schedule appointment within a specific time frame • A scheduled appointment • Oxygen therapy • Physical therapy • Occupational therapy • DME • VNA	

Data Element Name:	Postal Code

Collected For:	All MassHealth Records

Definition:	The postal code of the patient's residence. For the United States zip codes, the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

Suggested Data Collection Question:	What is the postal code of the patient's residence?

Format:	**Length:**	9
	Type:	Alphanumeric
	Occurs:	1

Allowable Values:	Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "Non-US."

Notes for Abstraction:	If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

Suggested Data Sources:	Face sheet Social service notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Previous Infant with Invasive GBS

Collected For:　MAT-1

Definition:　Documentation that the patient delivered a previous infant with invasive GBS disease.

Suggested Data Collection Question:　Is there documentation that the patient delivered a previous infant with invasive GBS disease?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes)　There is documentation that the patient delivered a previous infant with invasive GBS disease.

N (No)　There is no documentation that the patient delivered a previous infant with invasive GBS disease or unable to determine from medical record documentation.

Notes for Abstraction:　None

Suggested Data Sources:　History and physical
Prenatal record
Physician progress note

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Primary Physician or Other Health Care Professional for Follow-up Care
Collected For:	CCM-2
Definition:	Primary Physician refers to the physician responsible for overseeing the continued care of the patient immediately after discharge/ post-discharge (ex: Internist, Pediatrician, or Psychiatrist). Other Health Care Professional refers to any other medical specialist that may be involved in the continued care process (ex: surgeon, cardiologist, nurse practitioner etc).

A transition record that included the name of the Primary Physician or other Health Care Professional or site designated for follow-up care.

Suggested Data Collection Question:	Does the Transition Record include the _name of the_ Primary Physician or other Health Care Professional or site designated for follow-up care?
Format:	**Length:** 1 **Type:** Alphanumeric **Occurs:** 1

Allowable Values:

Y (Yes)   The transition record includes the _name of the_ Primary Physician or other Health Care Professional or site designated for follow-up care.

.

N (No)   The transition record does not include the _name of the_ Primary Physician or other Health Care Professional or site designated for follow-up care.

Notes for Abstraction:

The primary physician or other health care provider's name must be specified. The exception is for a _site of care_ such as a nursing home when the physician name may not be known. In this case the _site_ name must be documented.

The VNA or home health agency is not acceptable as a Primary Care Physician or other Health Care Professional designated for follow-up care.

If the patient is transferred to the next _site of care_ and the physician designated for follow-up is unknown, "_site_ physician" or _site of care_ name will be accepted and this element may be documented as Y (Yes).

If a follow-up appointment is made with a clinic where the physician / other health care professional is not known at the time of the appointment, this element may be documented as Y (Yes).
Ex. Follow up appointment made at GI Clinic in one week

In the case of a patient declining assignment of a PCP or clinic, the patient may be referred to the Emergency Room for follow up care.

If it is determined and documented by the physician that the patient requires no follow-up care, the _name of_ the patient's primary physician or other health care professional or site designated for care _must_ be documented.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Specific physician name • Specific health care professional • Clinic or site name • Transferred • _Emergency Room_	• _"PCP" "Primary Care Physician"_ • _VNA_

Data Element Name: Prior Uterine Surgery

Collected For: MAT-3

Definition: Documentation that the patient had undergone prior uterine surgery.

**Suggested Data
Collection Question:**   Is there documentation that the patient had undergone prior uterine surgery?

Format: **Length:** 1
     Type: Alphanumeric
     Occurs: 1

Allowable Values*:*   Y(Yes) The medical record contains documentation that the patient had undergone prior uterine surgery.

     N(No) The medical record does not contain documentation that the patient had undergone a prior uterine surgery OR unable to determine from medical record documentation.

Notes for Abstraction:

Suggested Data Sources: History and physical
     Nursing admission assessment
     Progress notes
     Physician's notes
     Prenatal forms

Guidelines for Abstraction:

Inclusion	Exclusion
The **only** prior uterine surgeries considered for the purposes of the measure are: • Prior classical Cesarean section *resulting in a vertical incision into the upper uterine segment* • Prior myomectomy • Prior uterine surgery resulting in a perforation of the uterus • History of a uterine window noted during prior uterine surgery • History of uterine rupture requiring surgical repair	

Data Element Name:	Provider ID
Collected For:	All MassHealth Records
Definition:	The provider's _ten_ digit acute care Medicaid, six digit Medicare provider or ten digit national provider identifier.
Suggested Data Collection Question:	What is the provider's _ten_ digit acute care Medicaid or six digit Medicare or ten digit national provider identifier?

Format:

Length:	10	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values:	Any valid _ten_ digit Medicaid or six digit Medicare or ten digit national provider ID.
Notes for Abstraction:	Hospitals must submit either their valid Medicare or Medicaid Provider ID or their National Provider ID for all MassHealth measure files or crosswalk files.
Suggested Data Sources:	Administrative record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Provider Name

Collected For: All MassHealth Records

Definition: The name of the provider of acute care inpatient services.

**Suggested Data
Collection Question:**   What is the name of the provider of acute care inpatient services?

Format:

Length:	60	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values: Provider name

Notes for Abstraction: The provider name is the name of the hospital.

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Race
Collected For:	All MassHealth Records
Definition:	The patient's self-reported race as defined by the Massachusetts *regulation noted in Section 2 of this EOHHS manual.*
	The definition of "Race" data element categories in the Massachusetts regulation differ from the CMS National Hospital Inpatient Quality Measures reporting requirement.
Suggested Data Collection Question:	What is the patient's self-reported race?

Format:
Length:	6	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values:

Select one:

Code	Race
R1	American Indian or Alaska Native:
R2	Asian:
R3	Black / African American:
R4	Native Hawaiian or other Pacific Islander:
R5	White.
R9	Other Race:
UNKNOW	Unknown / not specified:

Notes for Abstraction:

As noted in Section 2, Table 2.3 comparison chart, the Massachusetts regulation codes and allowable values for the "Race" data element differ from CMS reporting requirement. Hospitals must use the *Massachusetts regulation* race codes and allowable values when preparing all MassHealth data files for submission.

Only collect race data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.

If the medical record contains conflicting documentation on patient self-reported race, abstract the most recent dated documentation. If the medical record contains multiple patient self-reported races on one document, abstract the first self-reported race listed (e.g. – Black/Asian, select Black).

If the patient self reports as Hispanic, the Race selected is "Other Race".

If codes and allowable values, other than those listed above, are documented in the medical record, a crosswalk that links the hospitals' codes/values to the *Massachusetts regulation* requirements must be provided for chart validation.

Suggested Data Sources:

Administrative records
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusions	Exclusion
(OMB definitions) • **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachment, e.g. any recognized tribal entity in North and South America (including Central America), Native American. • **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. • **Black / African American:** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro", can be used in addition to "Black or African American". • **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. • **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa, e.g., Caucasian, Iranian, White. • **Other Race:** A person having an origin other than what has been listed above. • **Unknown:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).	None

Data Element Name: Reason for Inpatient Admission

Collected For: CCM-2

Definition: The reason for inpatient admission describes the patient's chief complaint, reason for admission, or diagnosis at time of admission.

A transition record that included the Reason for Inpatient Admission.

Suggested Data Collection Question: Does the Transition Record include the Reason for Inpatient Admission?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes)   The transition record includes the Reason for Inpatient Admission.

N (No)   The transition record does not include the Reason for Inpatient Admission.

Notes for Abstraction: Documentation of a diagnosis, symptoms, or procedure is acceptable for Reason for Admission.   The Reason for Inpatient Admission must be documented and differentiated from the Discharge Diagnosis on the Transition Record.

The Reason for Inpatient Admission may be documented the same as the Discharge Diagnosis for certain diagnoses. For example, a patient's admission diagnosis is Pneumonia and the discharge diagnosis is pneumonia.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
This list is not all-inclusive • Reason for Admission • Admission diagnosis • Primary diagnosis • Chief complaint	

Data Element Name:	Reconciled Medication List
Collected For:	CCM-1
Definition:	A Reconciled Medication List refers to the formal process of identifying all medications to create the most complete and accurate list and comparing the list to those in the patient's record or medication orders at the time of discharge.
	The Transition Record included the reconciled list received by the patient/caregiver(s) at the time of discharge.
Suggested Data Collection Question:	Did the patient/ caregiver(s) receive a copy of the reconciled medication list at the time of discharge?
Format:	**Length:** 1 **Type:** Alphanumeric **Occurs:** 1
Allowable Values:	Y (Yes) The patient/caregiver(s) received a reconciled medication list at the time of discharge.
	N (No) The patient/caregiver(s) did not receive a reconciled medication list that the time of discharge.
Notes for Abstraction:	The reconciled list should address medications taken prior to inpatient stay (to be continued or active), started during inpatient stay or upon discharge (new) and medications to discontinue at discharge.

Discontinued – Medications that should be discontinued or held after discharge, AND
Continued – Medications (including any prescribed before inpatient stay and any started during inpatient stay) that patient should continue to take after discharge, AND
New – Newly prescribed medications that patient should begin taking after discharge.

In the case of electronic health records, when determining that the New, Continued, and Discontinued sections of the medication reconciliation form are present, if one or more of the sections is missing, and it is determined that there are no medications ordered that would be included in those sections, you may answer "YES" to this element.
    Example: If there are no medications to be discontinued at discharge, and there is no discontinued section in the electronic health record due to this fact, then this would be acceptable.

All 3 categories of continued, new, and discontinued must be addressed for the patient but do not need to be labeled separately. For instance, a medication reconciliation form with the category title "medications to take" is acceptable documentation for the continued and new categories.

A reconciled medication form that does not list discontinued medications must state clearly to the patient that "medications not listed should be discontinued" or "only medications listed should be taken".

In the event the medication reconciliation form is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.

Prescribed dosage, instructions, and intended duration if applicable (ex Amoxicillin PO x 10 days), must be included for each continued and new medication list.

If discharge medications are noted using only references such as "continue home meds", "resume other meds, " or "same medications," rather than list the names of the discharge medications, the abstractor should select N (No).

Oxygen should not be considered a medication.

Medication which the patient will not be taking at home (and/or the caregiver will not be giving at home) are NOT required in the medication list included in the written discharge instructions (e.g., monthly B12 injections, intermittent IV dobutamin, Natrecor infusions, dialysis meds, chemotherapy)

If the patient refused written discharge instructions/ material which addressed discharge medications, select Y(Yes).

If the patient was given written discharge medication instructions only in the form of written prescriptions, select N(No).

Suggested Data Sources: Medication Reconciliation Form provided to the patient at discharge

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name:	Sample
Collected For:	All MassHealth Records
Definition:	Indicates if the data being transmitted for a hospital has been sampled, or represent an entire population for the specified time period.
Suggested Data Collection Question:	Does this case represent part of a sample?

Format:	**Length:**	1
	Type:	Alphanumeric
	Occurs:	1

Allowable Values:	Y (Yes)	The data represents part of a sample.
	N (No)	The data is not part of a sample; this indicates the hospital is abstracting 100 percent of the discharges eligible for this topic.

Notes for Abstraction:	None
Suggested Data Sources:	Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Sex
Collected For:	All MassHealth Records
Definition:	The patient's documented sex on arrival at the hospital.
Suggested Data Collection Question:	What was the patient's sex on arrival at the hospital?

Format:

	Length:	1
	Type:	Alphanumeric
	Occurs:	1

Allowable Values:

M = Male
F = Female
U = Unknown

Notes for Abstraction:

Collect the documented patient's sex at admission or the first documentation after arrival

Consider the sex to be unable to determine and select "Unknown" if:
- The patient refuses to provide their sex
- Documentation is contradictory
- Documentation indicates the patient is a transsexual
- Documentation indicates the patient is a hermaphrodite

Suggested Data Sources:

Consultation notes
Emergency department record
Face sheet
History and physical
Nursing admission notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Spontaneous Rupture of Membranes
Collected For:	MAT-3
Definition:	Documentation that the patient had spontaneous rupture of membranes (SROM) before medical induction and/or cesarean section.
Suggested Data Collection Question:	Is there documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section?

Format:

Length:	1	
Type:	Alphanumeric	
Occurs:	1	

Allowable Values:

Y (Yes) There is documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section

N (No) There is no documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section OR unable to determine from medical record documentation.

Notes for Abstraction:

If the patient's spontaneous rupture of membranes is confirmed before medical induction and/or cesarean section by one of the following methods, select the allowable value "Yes"

- Positive ferning test
- Positive nitrazine test
- Positive pooling (gross fluid in vagina)
- Positive Amnisure test or equivalent
- Patient report or SROM prior to hospital arrival

Suggested Data Sources:

History and physical
Nursing notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Studies Pending at Discharge
Collected For:	CCM-2
Definition:	Studies pending at discharge refers to any medical tests performed during hospitalization, but whose final results were unavailable at the time the patient was discharged, and therefore could not be reviewed by clinicians prior to hospital discharge.
	A transition record that included the Studies Pending at Discharge or documentation that no studies are pending.
Suggested Data Collection Question:	Does the Transition Record include documentation of Studies Pending at Discharge or that no studies were pending?
Format:	**Length:** 1 **Type:** Alphanumeric **Occurs:** 1

Allowable Values:

Y (Yes)	The transition record includes documentation of studies pending at discharge or documentation that no studies were pending.
N (No)	The transition record does not include documentation of studies pending at discharge or documentation that no studies were pending.

Notes for Abstraction: The definition requires documentation of Studies Pending at Discharge or documentation of none. If there is documentation of No studies pending/ None/ N/A, the abstractor should select Y (Yes).

Any studies pending must be listed, not just documented as "Yes" on the transition record.

Studies pending do not include tests scheduled to be performed after discharge from inpatient care.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• No studies pending, None, NA • Tissue Pathology Studies • Radiology Studies • Biopsy Reports • CT Scan results • X-ray results • Lab results	

Data Element Name: Transition Record

Collected For: CCM-2

Definition: A transition record refers to a document (or set of documents), as defined by the hospital, that must contain the minimum core set of information relevant to the patient's diagnosis, treatment, and plan of care. The core set of required information data elements are as follows.

<div align="center">Core set of Required Elements (11):</div>

- Advance Care Plan
- Contact Information 24 hrs/7 days
- Contact Information for Studies Pending

- Current Medication List
- Medical Procedures & Tests
- Patient Instructions
- Plan for Follow-up Care

- Primary Physician/ Health Care Professional for Follow-up Care
- Discharge Diagnosis
- Reason for Inpatient Admission
- Studies Pending at Discharge

Suggested Data Collection Question: Did the patient/ caregiver(s) or the next _site_ of care for a transfer receive a transition record at the time of discharge?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes)   The patient/caregiver(s) _or the next site of care for a transfer_ received a transition record at the time of discharge.

    N (No)   The patient/caregiver(s) _or the next site of care for a transfer_ did not receive a transition record at the time of discharge.

Notes for Abstraction: _For a_ transition record that included any or all of the required elements received by the patient/ family caregiver at the time of hospital inpatient discharge, _select Y(Yes)_.

    The _required_ data elements _in a Transition Record_ may be found on a single source _document_ or multiple sources but _these sources_ must be provided to the patient/ caregiver _or the next site of care in the case of a transfer_.

    Documents used for the Transition Record may include, but are not limited to:
- Transition Record
- Discharge Instructions
- Transfer Forms
- Any document given to the patient/ family caregiver that includes ANY or ALL of the _required data elements_
- _Any document given to the next site of care for a patient transfer that includes ANY or ALL of the required data elements_
- _Physician Discharge Summary ONLY if given to the patient/ family caregiver or the next site of care in the case of a transfer._

    In the event the patient is transferred to another site of care and the transition record, that included any or all of the required elements, is given to the next site of care, the Transition Record may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site of care.

Documentation of evidence the patient/ family caregiver received the Transition Record includes:

- *Patient/ family caregiver signature on Transition Record*
- *Nursing documentation of patient receipt of Transition Record*
- *Physician/ Nurse signature on Transition Record*

The caregiver is defined as the patient's family or any other person over age 18 who will assume responsibility for managing the care of the patient after discharge. The caregiver term is differentiated from other health care professional entities that may assist in the care of the patient.

Suggested Data Sources: Transition Record
Discharge Instructions
Transfer Forms

Guidelines for Abstraction:

Inclusion	Exclusion
	Physician Discharge Summary: Do not abstract information from the physician discharge summary for CCM-2 (unless a copy of the physician discharge summary is given to the patient/caregiver *or the patient is a transfer*)

Data Element Name:	Transmission Date (*of Transition Record)*	
Collected For:	CCM-3	
Definition:	The Transmission Date refers to the month, day and year the Transition Record given to the patient/family caregiver was transmitted *to the next site of care*, physician, or other health care professional designated for follow-up care.	

Transmission *methods* may occur via fax, secure email, mail, or *via* mutual access *of an electronic medical record* (EMR). The transmission date may be the day of discharge or within the following two days.

Suggested Data Collection Question: What was the date *documented in the medical record* that the Transition Record was transmitted?

Format:

Length:	10 – MM-DD-YYYY (includes dashes)	
Type:	Date	
Occurs:	1	

Allowable Values:

MM	=	Month (01-12)
DD	=	Day (01-31)
YYYY	=	Year (2000 – 9999)
UTD	**=**	Unable to determine/ No transmission date

Notes for Abstraction: Any documentation used to complete the Transition Record must be transmitted with the Transition Record (ex. Medication Reconciliation Form, Discharge Instructions)

EMR -In the case of Electronic Medical Records (EMR), there must be documentation in the medical record or on the transition record by discharging staff of the date the information has been transmitted to the next provider of care.

MUTUAL ACCESS- In the case of mutual access, there must be documentation in the medical record or on the transition record of the date of notification to the provider that the patient has been discharged and the transition record elements are ready for review. The next provider of care having access to the EMR without documentation of notification is not enough to pass this measure.

If the Emergency Room *of the hospital* is the referral for follow-up *care*, *EMR* mutual access is the assumed answer and the date of discharge may be documented for the Transmission Date.

FAX- In the case of a fax transmission, there must be documentation in the medical record or on the transition record of the date the fax was sent to the next provider.

MAIL- If the transition record is sent by mail, the date of the mailing may be documented in the medical record or on the transition record as the Transmission Date.

HAND DELIVERY- A transition record given to the patient to hand carry to physician is not acceptable.

In the event the patient is transferred to another site of care where the plan for follow-up care will be determined at the time of discharge from that site, the discharge date should be used as the Transmission Date. Documentation of the discharge date also applies to patients discharged and admitted within the same site.

If the discharging physician is also the physician designated for follow up care, transmission of the Transition Record to the provider or provider practice is still required.

Transmission to the VNA does NOT meet the requirement for transmission to the physician or other health care professional designated for follow-up care and may not be abstracted as the transmission date.

The transition record should be transmitted to the next provider even if there is no follow-up care required.

Suggested Data Sources: Transition Record
Discharge Instructions
Physician Discharge Summary

Guidelines for Abstraction:

Inclusion	Exclusion
• Faxed • Secure Email • Mail • EMR with proper documentation of notification to next provider of care	• Hand carried by patient • *Transmission to the VNA*